STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING **01** B. WING _____	R **09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK A WATERS COMMUNITY	**1316 N TIBBS AVE** **INDIANAPOLIS, IN 46222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/21/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/01/15 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this PSR survey, Westpark a Waters Community was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consisted of two sections: the original section determined to be Type III (200) construction and the Addition was determined to be Type V (000) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 The facility has elected to utilize a Categorical Waiver pertaining to clean waste and patient record recycling containers.	{K 000}		